SPECIAL BULLETIN
(Dist: Physicians, Hospitals, Podiatrists, APNs, CRNAs, Clinics, DME, FQHCs, Laboratories, Optometrists, Radiologists, RHCs, MC+ Plans, Nurse Midwives)
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Missouri MEDICAID Bulletin

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1999 CPT AND HCPCS UPDATES

Missouri Medicaid converted to the 1999 version of the *Physicians' Current Procedural Terminology (CPT)* effective January 1, 1999. All claims received by GTE Data Services on or after April 1, 1999, regardless of the dates of service, should contain only those Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS) procedure codes found in the 1999 CPT book or the 1999 Level II procedure codes. However, a two-month grace period (through May 31, 1999) will allow for processing of claims with the "old" procedure codes.

There are several changes as a result of the 1999 CPT updating. These include code deletions, terminology changes, and the addition of new codes. The Missouri Medicaid additions, deletions, and replacement codes are listed in this bulletin. (See Attachment B.) Due to the number of procedure codes involved, we are not able to include the procedure code descriptions and terminology changes for these codes. All of this information is included in the 1999 CPT book and providers should obtain and refer to this publication to assure proper coding.

A copy of the *Physicians' Current Procedural Terminology (CPT)* may be purchased by writing to the following address:

Order Department
American Medical Association
P.O. Box 7046
Dover, DE 19903-7046
Telephone Number: (800) 621-8335
Fax Orders: (312) 464-5600

ANESTHESIA SERVICES

Please note the procedure codes in the Anesthesia Section of the 1999 CPT book (Procedure Codes 00100-01999) should not be used when billing Missouri Medicaid for anesthesia services. Anesthesia services should continue to be billed by using the appropriate Type of Service (TOS): G - Anesthesiologist; W - Certified Registered Nurse Anesthetist (CRNA); or S - Supervision of Anesthesia, with the procedure code for the surgery performed. When multiple procedures were performed, use the procedure code for the major procedure and the total number of minutes for the entire surgery.

DURABLE MEDICAL EQUIPMENT 1999 HCPCS UPDATE

As a result of the 1999 HCPCS updates, the following procedure codes have been added as covered or the description of an existing procedure code has been changed effective for dates of service January 1, 1999.

New Codes Added for HCY Recipients Only

PROCEDURE CODE	DESCRIPTION	TOS	REIMBURSEMENT GUIDELINES	MEDICAID MAXIMUM ALLOWED AMOUNT
A4614	Peak expiratory flow rate meter, hand held	A	Medical Necessity	$ 19.00
A5200	Percutaneous catheter/tube anchoring device, adhesive skin attachment	A	Medical Necessity	$ 9.00
A6200	Composite dressing, pad size 16 sq. in. or less, without adhesive border, each dressing	A	Medical Necessity	$ 8.00
A6201	Composite dressing, pad size more that 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing	A	Medical Necessity	$ 18.00
A6202	Composite dressing, pad size more than 48 sq. in., without adhesive border, each dressing	A	Medical Necessity	$ 30.00

New Codes Added

PROCEDURE CODE	DESCRIPTION	TOS	REIMBURSEMENT GUIDELINES	MEDICAID MAXIMUM ALLOWED AMOUNT
L1690	Combination, bilateral, lumbo-sacral, hip, femur orthosis providing adduction and internal rotation control	A	Medical Necessity	$1270.00

L1847	Knee orthosis, double upright with adjustable joint, with inflatable air support chamber(s)	A	Medical Necessity	$ 378.00
PROCEDURE CODE	**DESCRIPTION**	**TOS**	**REIMBURSEMENT GUIDELINES**	**MEDICAID MAXIMUM ALLOWED AMOUNT**
L3675	SO, vest type abduction restrainer, canvas webbing type, or equal	A	Medical Necessity	$ 105.00
L5968	All lower extremity prosthesis, ankle, multiaxial shock absorbing system	A	Medical Necessity	$2391.00
L5975	All lower extremity prosthesis, combination single axis ankle and flexible keel foot	A	Medical Necessity	$ 305.00
L5988	All lower extremity prosthesis, combination vertical shock and multiaxial rotation/torsional force reducing pylon	A	Medical Necessity	$1315.00
L6693	Upper extremity addition, external locking elbow, forearm counterbalance	A	Medical Necessity	$1868.00

Description Changes

PROCEDURE CODE	DESCRIPTION
L3500	Orthopedic shoe addition, insole, leather
L3510	Orthopedic shoe addition, insole, rubber
L3520	Orthopedic shoe addition, insole, felt covered with leather
L3530	Orthopedic shoe addition, sole, half
L3540	Orthopedic shoe addition, sole, full
L3550	Orthopedic shoe addition, toe tap standard
L3560	Orthopedic shoe addition, toe tap, horseshoe
L3570	Orthopedic shoe addition, special extension to instep (leather with eyelets)

L3580	Orthopedic shoe addition, convert instep to velcro closure
L3590	Orthopedic shoe addition, convert firm shoe counter to soft counter
L3595	Orthopedic shoe addition, march bar
PROCEDURE CODE	**DESCRIPTION**
L3649	Orthopedic shoe, modification, addition or transfer, not otherwise specified
L4398	Foot drop splint, recumbent positioning device
L5840	Addition, endoskeletal knee/shin system, 4-bar linkage or multiaxial, pneumatic swing phase control
L8210	Gradient compression stocking, custom made
L8220	Gradient compression stocking, lymphedema
L8230	Gradient compression stocking, garter belt
L8239	Gradient compression stocking, not otherwise specified
L8420	Prosthetic sock, multiple ply, below knee, each
L8430	Prosthetic sock, multiple ply, above knee, each
L8435	Prosthetic sock, multiple ply, upper limb, each
L8470	Prosthetic sock, single ply, fitting, below knee, each
L8480	Prosthetic sock, single ply, fitting, above knee, each
L8485	Prosthetic sock, single ply, upper limb, each

IMMUNIZATION ADMINISTRATION CODES (CHANGE IN POLICY)

Two new procedure codes have been added (90471 and 90472) for the professional component of immunization administration services. In the past, Missouri Medicaid has allowed providers to bill a minimal office visit when a patient comes into the office to receive an immunization only. With the implementation of these codes that will no longer be an option. The provider may bill the appropriate administration code and the drug may continue to be billed on the Pharmacy Claim form using the national drug code (NDC). If a significant, separately identifiable Evaluation and Management (E/M) service, (Procedure Codes 99201 - 99215), is performed, the appropriate E/M code may be billed in addition to the administration code.

These procedure codes do not apply to the immunizations included in the Vaccine for Children (VFC) Program. Providers should continue to use the appropriate CPT immunization procedure code with

the YG modifier to bill for the administration of VFC immunizations.

The administration procedure codes may not be billed by federally qualified health centers (FQHCs) or rural health clinics (RHCs) as outlined by federal guidelines. The administration of any medications, including immunizations, is included in the encounter rate and additional reimbursement is not allowed.

ADD-ON PROCEDURE CODES

The procedure codes listed below are commonly carried out in addition to the primary procedure performed. These additional or supplemental procedures are designated as "add-on" codes with a "+" symbol in the 1999 CPT book. Add-on codes can be readily identified by specific descriptor terminology which includes phrases such as "each additional" or "(List separately in addition to primary procedure)". The "add-on" code concept in CPT applies only to add-on procedures/services performed by the **same** practitioner. These codes describe additional intra-service work associated with the primary procedure. Add-on codes are always performed in addition to the primary service/procedure, and must **never** be reported as a stand-alone code. In addition to payment for the primary service/procedure, the add-on codes will also be paid at 100% of the Medicaid maximum allowable.

11001	22328	37206	61611	64872	78496
11101	22585	37208	61612	64874	88141
11201	22614	37250	61795	64876	88155
11732	22632	37251	63035	64901	90781
11922YG	26125	38102	63048	64902	92547
15001	26861	38746	63057	67320	92978
15101	26863	38747	63066	67331	92979
15121	27358	43635	63076	67332	92981
15201	27692	44015	63078	67334	92984
15221	32501	44121	63082	67335	92996
15241	33530	44139	63086	67340	92998
15261	33572	44955YG	63088	69990	93320
15351	33924	47001	63091	74301	93321
15401	33961	47550	63308	75774	93325
15787	35390	48400	64443	75946	93571
17003	35400	49568	64623	75964	93572
19001	35500	49905	64727	75968	93623
19126	35681	56606	64778	75993	95920
19291	35682	58611	64783	75996	95962
22103	35683	59525	64787	76125	95973
22116	35700	60512	64832	78020	95975
22216	36218	61609	64837	78478	96412
22226	36248	61610	64859	78480	96423

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PROCEDURE CODE REVISIONS

Due to the large volume of substantially altered procedure descriptors for this year's conversion, a number of codes have been reviewed, and the descriptions and fees adjusted to accommodate these changes. Effective January 1, 1999, fees for the following list of procedure codes have been revised. Refer to the 1999 CPT book for the current description for each base code.

11000	15937	23222	24200	26040	26416
11001	15946	23330	24201	26045	26418
11100	15956	23331	24305	26070	26420
11101	15958	23332	24310	26075	26426
11200	17004	23405	24360	26080	26428
11200W1	19000	23406	24361	26100	26432
11201	19001	23420	24362	26105	26433
11730	19125	23450	24363	26110	26434
11730W1	1912550	23455	24470	26145	26437
11732	19126	23465	24498	26180	26440
11920YG	19290	23466	24800	26230	26442
11921YG	19291	23470	24802	26235	26445
11922YG	20240	23472	25000	26236	26449
15000	20245	23490	25028	26250	26450
15100	23000	23491	25031	26255	26455
15101	23020	23620	25035	26260	26460
15120	23035	23625	25065	26261	26471
15121	23040	23625W1	25066	26262	26474
15200	23044	23630	25085	26350	26476
15201	23075	23665	25107	26352	26477
15220	23076	23670	25447	26356	26478
15221	23100	23800	25800	26357	26479
15240	23101	23802	25805	26358	26480
15241	23105	23930	25810	26370	26483
15260	23106	23931	25820	26372	26485
15261	23130	24000	25825	26373	26489
15350	23180	24065	25830	26390	26490
15400	23182	24066	26020	26392	26492
15786	23184	24140	26025	26410	26494
15787	23220	24145	26030	26412	26496
15936	23221	24147	26034	26415	26497

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Procedure Code Revisions (Continued)

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COVERAGE FOR HYALGAN AND SYNVISC SERVICES

Effective for dates of service January 1, 1999, and after, Sodium Hyaluronate (Hyalgan), procedure code J7315, and Hylan G-F 20 (Synvisc), procedure code J7320, are covered for the treatment of osteoarthritis of the knees with these procedure codes. Hyalgan is reimbursed $120.76 per injection and has a treatment plan of five injections administered once per week for five consecutive weeks. Synvisc is reimbursed $204.87 per injection and has a treatment plan of three injections administered once per week for three consecutive weeks. A treatment plan may be repeated if at least six months have lapsed since the prior series of injections, the records show significant improvement in pain and functional capacity, and there has been a reduction in the number of intra-articular steroid injections to the knees during the six month period.

The reimbursement will be for each weekly injection, not for the cost of the entire treatment series. If multiple dates of service are submitted on one claim form, each date of service and injection must be billed on a separate line and the reimbursement applied will be per weekly injection.

For dates of service **PRIOR** to January 1, 1999, continue to bill on the Pharmacy Claim form with the national drug code (NDC). For dates of service January 1, 1999, and after, bill on the HCFA-1500 claim form using the CPT procedure codes listed above.

IMMUNIZATION SCHEDULE

In accordance with the MC+ contracts, MC+ health plans are required to provide to MC+ enrolled individuals all medically necessary services contained in the standard benefit package. MC+ health plans are required to keep immunizations and Healthy Children and Youth (HCY) screenings current according to schedules as specified by the Missouri Division of Medical Services.

The attached schedule (Attachment A) indicates new recommendations for childhood immunizations. The Recommended Childhood Immunization Schedule was developed by the Advisory Committee on Immunization Practices (ACIP). State Medicaid agencies are required by Section 1905(r) (1) of the Social Security Act to provide appropriate immunizations under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, also known as the Healthy Children and Youth (HCY) Program, according to the ACIP schedule. This schedule is reviewed annually by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

The changes indicate that vaccines are to be assessed and given if necessary during the early adolescent years.

The major change in the new schedule is as follows:

- The American Academy of Family Physicians (AAFP) feels that the decision to use the rotavirus (Rv) vaccine (which is shaded on the attached immunization schedule) should be made by the parent or guardian in consultation with their physician or other health care provider. **The first dose of Rv vaccine should not be administered before 6 weeks of age, and the minimum interval between doses is 3 weeks. The Rv vaccine series should not be initiated at 7 months of age or older, and all doses should be completed by the first birthday.**

Appropriate immunizations must be provided during a full HCY screening unless medically contraindicated or refused by the parent or guardian of the patient. When an appropriate immunization is not provided, the medical record must document why the immunization was not provided. As long as the medical record documents why the appropriate immunization was not provided, the provider may bill for a full HCY screen if all other screening components are performed.

COVERAGE FOR HOSPITAL/OBSERVATION CODES - PODIATRY

Recently, Missouri Medicaid reviewed all Evaluation and Management (E/M) procedure codes to ensure podiatrists (type of service 6) were allowed to bill and receive payment for all appropriate E/M procedures when provided in an observation room or hospital setting. The review identified several existing hospital/observation codes which a podiatrist is qualified to perform, but were not reimbursable by Missouri Medicaid. Podiatric providers meet the requirements for all components involved in providing these identified services in an observation room or hospital setting. Therefore, effective for all dates of service January 1, 1998, and after, Missouri Medicaid will reimburse podiatrists for the following procedure codes:

Procedure Code	Description
99217	Observation Care Discharge
99218	Initial Observation Care-Low Complexity
99219	Initial Observation Care - Moderate Complexity
99234	Observation or Inpatient Hospital Care - Low Complexity
99235	Observation or Inpatient Hospital Care - Moderate Complexity
99238	Hospital Discharge Day Management - 30 minutes or less
99239	Hospital Discharge Day Management - more than 30 minutes

ADULT PHYSICALS

One adult "preventive" examination/physical (including a well woman exam) per 12 months is covered by Missouri Medicaid. Physicals are also covered when required as a condition of employment. Diagnosis code V70, " General Medical Examination", should be used in these instances and billed under the appropriate Evaluation and Management code.

HERCEPTIN

Herceptin is covered by Missouri Medicaid for the treatment of patients with metastatic breast cancer. The drug is administered in the physician's office and may be billed on the Pharmacy Claim form using the national drug code (NDC). Herceptin is packaged in a multiple dose (440 milligram) powder-filled vial. **This drug is unique as it should be billed by MILLIGRAM rather than by vial**. Continue to bill all other powder-filled vials by the number of vials administered. The appropriate office visit may be billed in addition to the drug.